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H. E. T. MANNING, M. D., T. A. ASHBY, M. D.

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MARYLAND
MEDICAL JOURNAL.

VOL. I. BALTIMORE, MAY, 1877. NO. 1.

ORIGINAL PAPERS.

ABUSES OF NITRATE OF SILVER IN THE TREATMENT OF EYE DISEASES.

BY JULIAN J. CHISOLM, M. D., PROFESSOR OF EYE AND EAR DISEASES IN THE UNIVERSITY OF MARYLAND.

From the frequency with which Nitrate of Silver solutions are prescribed by Physicians for the various inflammatory affections of the eye, regardless of the degree of congestion or character of the structure involved, one would be led to believe that there is but one disease for all eye affections, to which the general term Ophthalmia is well suited, and that the panacea for all phases of this disease is Nitrate of Silver, applied locally, either in solid form or in solutions of varied strength. This caustic, *so active for good in a few of the inflammatory troubles of the eye, so potent for evil in by far the majority of acute eye diseases*, has ever been a favorite remedy with physicians. They imagine that no injury can possibly be committed through the application of a Nitrate of Silver solution into an eye in which the vessels are injected, more especially if the congestion has been of some duration.

How many thousand eyes have been destroyed through this mistaken practice can easily be imagined; for certain it is that those physicians who devote exclusively their time and attention to the diseases of the eye have daily brought to their notice the most serious damage induced, at the hands of general practitioners, through the too liberal use of this dangerous salt. No eye lesion seems to be safe from its intrusion. The few that need it, and the many which resent its application, are equally made to feel the

weight of its universal application. When consulted for an eye inflammation very few physicians can resist the temptation of writing a prescription for a caustic eye drop. The Opthalmic surgeon, on the contrary, very rarely makes use of it, except in cases of acute inflammations of the front covering of the eye ball, purely and primarily a conjunctivitis; and in some of the inflammatory troubles of the lids. If the remedy is in this way restricted it can do most efficient work. When we find it prescribed for scleral, corneal, iritic, choroidal, retinal, and lenticular diseases, and in even the injected condition resulting from the over straining of the accommodating apparatus, in fact in every painful condition of the eye accompanied by injections of the conjunctival vessels, and with its appliction bringing always trouble in its train, we may well question the propriety of retaining this caustic salt among the list of remedies to be used by the general practitioner in the treatment of eye diseases.

The foundation for all of this mischief lies in a defective diagnosis, and the indifference in locating eye inflammations as regards the tissue involved. In the large cities, where specialists are at hand, the physician excuses himself from assuming the responsibility in eye cases, on the ground that those whose everyday experience must make them more familiar with eye troubles, can be readily consulted. Outside of the large cities the general practitioner must do this work, as coming strictly within his line of duty, and should therefore try to approximate to a truthful diagnosis, and so locate the seat of the pathological lesion that the caustic application, if a favorite remedy, might be used with discrimination.

Unfortunately, with the majority of practitioners, the pathology of the eye, is theoretically known, but is practically in inextricable confusion. Conjunctivitis is to them the appreciable disease. The redness of the surface constantly misleads them into the belief that the primary seat of the inflammation is in the mucous lining membrane. They seem to forget that the vascular net work which gives the eye so liberal a supply of blood, is distributed to all of the coats, so that, should a masked congestion be induced in any one of the eye coats, contiguous branches—or rather continuous

branches from the same general vascular supply in contiguous coats —must also exhibit more or less defective action and consequent injection. This surface congestion of vessels of the conjunctiva, as a secondary state, constantly accompanies inflammations of the cornea, iris or choroid layers, and as constantly masks the true pathological lesion to those who only see eye cases now and then. This is more especially the case in inflammations of the iris. Seldom do we find a case of iritis, however well marked, successfully diagnosed, and consequently it is equally rare to have a case for treatment at second hands, which has not run the gauntlet of astringent or cauterizing applications.

There are some thoroughly proved facts which find their way very slowly into general professional recognition. If there is any one remedy which the specialist values beyond all others, it is the active principle of Belladonna, a diagnostic as well as therapeutic agent, and he never loses sight of its great utility. Although he may be ever so familiar with the many phases of iritis and the general symptoms by which the disease is to be recognized, he invariably makes his diagnosis absolute, by instilling a drop of a solution of the Neutral Sulphate of Atropia into the eye. Should a thoroughly and uniformly dilated pupil respond in a half hour to the drop, he then knows that no iritis exists, and this element, in a doubtful diagnosis, is altogether removed. Should the dilatation of the pupil be tardy and irregular the diagnosis of iritis is absolutely made out, especially when, upon inspection in a good light, the adhesions between the iris and lens surface are clearly brought into view.

The source of greatest danger to the eye in iritic inflammations is in the juxtaposition of the iris and lens. The iris when gorged with blood, can only swell towards the pupillary area, diminishing this orifice and largely increasing its contact with the capsule of the lens. With the rapid proliferation of its cell elements pigmented as they are, a black glutinous substance is speedily formed as the result of active congestion; this sticks the iris to the contiguous lens surface. A very few days suffices for firmly organized adhesions and then such an eye is irrevocably damaged. During these early stages of the affection, the dullness of color

of the iris is not half so conspicuous as the scleral or conjunctival redness. As this congestion is never excessive, the case is usually called by the family physician a simple cold in the eye, and just such a trivial disease as every doctor must himself take care of if he desires to retain his self respect and the good opinion of his patients. A solution of Nitrate of Silver is ordered to be dropped into the eye three times a day, as an established remedy for Catarrhal Ophthalmia, and the trouble begins. The specialist sees the case later, after the adhesions have become firm and the damage has been done, and usually too late to correct the mistake committed.

In an other class of affections, viz: corneal inflammations, the use of astringents, including caustics is very questionable. Because Nitrate of Silver is so often used with advantage for the stimulation of ulcers on all parts of the surfaces of the body, it does not follow that it should be an equally good preparation for ulcers of the cornea; yet on general principles, it is constantly applied to this class of diseases, and most frequently with the most disastrous results. To acute corneal ulceration Nitrate of Silver is particularly irritating; and as a rule soothing applications are especially called for. Now and then in a case of chronic corneal ulceration which refuses to heal under the sedative plan of local treatment usually adopted, an effort may be made to change the action by stimulation. Under such conditions, touching the surface with a point of Nitrate of Silver is an experiment worthy of trial.

The common forms of corneal ulcers met with in practice, occur in children, in some one of the many forms of phlyctenular corneitis. In this disease the vesicles or pustules often break down into ulcers which threaten to perforate into the anterior chamber, and do serious damage to the visual organ. It is in such cases that the physician is so prone to use the Nitrate of Silver in solution and as experience shows, he had far better do nothing. Such ulcers are local manifestations of a general systemic disturbance, often of an enfeebling nature, requiring in connection with general tonics and good hygiene, the local use of sedatives. It is in such common cases that an atropia solution again comes in as a local agent of inestimable value. It is so soothing in its character, that after

a few applications the eye becomes stronger, it weeps less, stands the light better, gives less pain, and in fact may be said already to be in the way of convalescence.

In scleral injections, recognized by the uniform pink hue given to the white of the eye by the injection of the numerous small vessels which so freely ramify in this sclerotic coat, so constantly mistaken for the redness of conjunctivitis, the instillation of Nitrate of Silver is not to be thought of. This peculiar eye disease, usually engrafted upon a rheumatic diathesis, needs general remedies for its control. The local remedies required should be of a soothing nature, and as the iris is often involved in an extension of the pathological lesion, a solution of atropia becomes peculiarly applicable.

We could hardly conceive of an injection of the conjunctiva sufficiently great to permit a mistaken diagnosis in glaucomatous affections, when we take into consideration the intense head pains which belong to this serious intra-ocular malady, had I not now under care an acute glaucoma with rapidly deteriorating sight and the usual paroxysms of intense suffering, for which Nitrate of Silver was in all seriousness prescribed after due consultation. In many cases of chronic inflammations of the inner coats of the eye, we not only find the caustic solution in use, but used for so long a time that the scleral tissues have become permanently stained, an ever present evidence of the marked abuses of this remedy in the treatment of eye inflammations.

Every-day experience in observing the direct injury committed by the too liberal use of this potent agent, well worthy of its ancient name of infernal stone, induces us to condemn the prescribing of caustic eye drops by the general practitioner. For such general use I would have Nitrate of Silver scratched from the list of eye remedies. Better far omit its use in the very few cases in which it would prove beneficial, than have it do harm in the very many cases in which it is improperly applied.

While condemning the caustic eye drop in the strongest terms, I can not too strongly commend instead of it, the active principle of Belladonna, a remedy seldom used by the general practitioner, and yet one of the very best applications in the majority of the

acute inflammations of the eye. Every physician should keep on hand a solution of the Neutral Sulphate of Atropia, four grains to the ounce of Rose-water, and while habit now leads him to the caustic bottle, let a better judgment induce the acceptance of the atropia solution, as a most worthy substitute, to be instilled, if need be, into every inflamed eye which is presented for his treatment. With this remedy, even when blindly used, he is not likely to do permanent harm at any time, and will undoubtedly save many an eye, which, under the present method of irritating treatment, is doomed to destruction.

An aphorism for the treatment of the eye inflammations and for the use of general practitioners may be readily formulated:—For eye inflammations use Caustic very seldom, use Atropia very often.

A CASE OF DIFFUSE MELANOTIC SARCOMA OF THE BRAIN, FOLLOWING SAME DISEASE IN THE ORBIT.

BY OSCAR J. COSKERY, M. D., PROFESSOR PRINCIPLES AND PRACTICE OF SURGERY, COLLEGE OF PHYSICIANS AND SURGEONS, BALTIMORE.

George S——, aged 55 years, German laborer, was admitted into St. Joseph's Hospital January 10th, 1877. His own account is the following: Has been in America 30 years, and was "never sick" until about 4 years ago, when he first began to complain of pain in and about left eye, with loss of vision. His family history was good. For the eye trouble he had applied to Prof. J. J. Chisolm of this city, who, in response to enquiries, wrote me as follows: "The patient has been suffering from disease of the left eye for one year—now (October 14th, 1873,) a large protruding fungus, bleeding at times, of size of hickory-nut, protruding from the front of eyeball, taking the place of the cornea. Enucleation was performed," (on the above date), "the conjunctival wound healing up kindly and the case was discharged temporarily cured. The tumor was a malignant sarcoma, commencing in the eye chamber, in the choroidal tissue." After this operation the man was able to attend to his business for one year, when a return of the trouble again obliged him to apply for relief. Prof. Jos. A. White, to whom the patient applied, writes me as follows:

"George S——, entered the Washington University Hospital November 4th, 1874. He was in an enfeebled condition, due partly to a constant hemorrhage from an intra-orbital tumor, and partly to nervous exhaustion and want of sleep, the result of intense ciliary neuralgia. The tumor was a large black mass, completely filling the orbit and protruding from between the lids, of about the size of a large egg."

The growth was removed and only three points of attachment found, two above and one below. The "bleeding was stopped with the actual cautery and cavity packed with chloride of zinc

paste. One week later I again used the paste, and a few days after healthy granulations sprang up and filled the cavity. It healed nicely and the man was discharged, temporarily cured and his health re-established. In October 1876, or 23 months after the operation, I examined him carefully and found no symptoms of a recurrence."

As appears by the above, nearly two years of good health followed the last operation, but a return of the pain toward the latter part of 1876, and its steady increase in intensity, caused the patient to apply at St. Joseph's Hospital for admission.

The symptoms then were an expression of great pain, which pain he referred to orbit and left side of the nose, and the muscles of that side of the face were spasmodically contracted; the corrugator supercilii, and orbicularis being principally involved. The flap formed of the lids at the last operation was perfect. The patient suffered also from occasional headaches, and the pains were most servere at night. There were short intervals of comparative ease, but the sense of discomfort never entirely left him. Upon examining the orbit, a small tubercle could be felt under the skin of the upper eyelid, seemingly firmly attached above, and the orbit was about half filled with what was supposed to be the stump left by former operations. This mass, or stump, felt hard and resistent, and although the eyelids were firmly contracted upon it, they were nowhere adherent to it. The small tubercle, the most prominent suggestion of a new growth, was situated just back of the orbital arch, midway between the two canthi, about the size of a pea, and did not give rise to pain on handling. The patient's appetite and general condition were good; there was no cough, or any symptom to attract attention to either chest or abdomen, and, as he said himself, "if the eye did not trouble me I would be all right." His intellectual faculties were bright, for a for a man in his condition of life.

The man was up and about, his general health remaining good and only requiring an opiate at night in order to procure sleep, until February 25th, 1877, when, upon rising in the morning, (having slept moderately well the night before,) he noticed that he could not button his clothing in dressing. At the visit on this date I

found the patient's intellect clear, he was unable to hold any small object in either hand for any time, he walked with a shuffling gait, but the amount of paralysis existing was evidently greater in the right than in the left limbs. There was no hyper -or anæsthesia of the body, nor could I perceive, with the hand, any difference of temperature of the two sides. Two weeks ago patient had his attention called to a tumor on the right side of the neck, which he now pointed out to me. It gave rise to no pain, was about 1 by 2 inches in size, not connected with the skin, slightly lobulated, non-expansile but rising at each pulsation of the artery, hard and resistent to the feel. It was evidently an enlarged cervical gland.

March 4th.—Has not perceptibly changed since last note, except, perhaps, that hands have become more helpless. Patient remains in bed but takes food well. Does not complain so much of pain as before paralytic attack. To-day had a convulsion, probably epileptiform, which lasted, according to account of the nurse, about 10 minutes. Did not bite tongue. I saw him two hours after the attack. He was perfectly sensible but remembered nothing of the convulsion.

March 11th.—Has had no return of the fits, but on this date I found patient paralyzed on *left* side of face and body. The right side of the face was only slightly drawn, but the patient was unable to whistle. Tongue protruded slowly but straight; speech thick and indistinct; intellection slow but good; patient answering questions correctly. The condition of the left upper extremity was that of irritative paralysis, the biceps, brachialis anticus, and flexors and pronators being tonically semi-contracted, with intermitting semi-contractions, or rather startings of the muscles generally. The patient was unable to move the limb voluntarily. The left leg was perfectly flaccid, did not contract reflexly when sole of foot was tickled, and there were no muscular startings of it. Movements of right limbs good. Pupil of only eye in mid-state. Bowels have not been moved for a week, tongue slightly coated, and there is a decided difference, perceptible to the hands, between the two sides of the body, the left limbs being the warmer.

March 12th.—There are not such violent muscular startings as

were present yesterday. They are now confined to the muscles of the anterior and inner portion of forearm, (the flexors and pronators), and the long extensor of the left big toe. Paralysis of left side of face, and, so far as voluntary movements go, of the left arm and leg, is complete; anæsthesia of paralyzed parts, patient not feeling pinch or prick; tongue very slightly deflected to left; mental condition unchanged.

March 13th.—Muscular contractions weaker, and now confined to flexors and prônators of arm and common extensor of toes, instead of the long extensor of big toe, as yesterday. Anæsthesia is *not* present and pinching or pricking paralyzed parts gives rise to pain. Decided hebetude of intellectual faculties. Very slight difference in temperature of two sides.

March 14th.—While patient is sleeping profoundly the only muscles seen to be starting are the posterior interossei of the left hand. When waked, after some trouble, the flexors, pronators and common extensors of toes, again started off. Patient is stupid, and has passed water unconsciously. The right eye is firmly closed and a slight purulent discharge is issuing from between lids; which, on being separated, showed palpebral conjunctivitis. The patient has been perfectly quiet, on his back, and in present condition for last eighteen hours. It is only with difficulty that he can be induced to answer when spoken to, and is then scarcely intelligible. The tumor on right side of neck, above spoken of, is in about same condition as when first seen.

March 15th.—Seemingly decidedly better; more bright, answering questions readily and correctly, conjunctivitis has ceased, no starting of any muscles, but left fore-arm is rigidly semi-flexed. Lower extremities cold. Has made his wants known and has not soiled his bed since yesterday. Tongue coated, pointed out straight, and no curving of uvula. Complains of no pain.

March 16th—.Paralysis of face has disappeared, but patient's mental condition is certainly worse. Tumor of orbit has gone on increasing in size since admission, and now nearly fills orbital fossæ—near inner angle lids are adherent to tumor but over general surface skin moves freely.

March 17th.—Left side of face again perceptibly fallen. Though

not answering when spoken to, the patient still evidently understands, trying to whistle when told to do so &c. Both arms rigidly semi-flexed, can be straightened but soon return to former condition; fingers flexed over thumbs. Left leg not moved, but right moving freely. No reflex action of left leg. Again a very perceptibly higher temperature of left limb than of right.

March 18th.—Again passing water unconsciously. The patient's head is drawn to right side, face presenting over shoulder. The left sterno-mastoid is relaxed and the turning of head seems due to platysma-myoides, trapezius and deeper muscles of right side of neck. The head can be turned towards left with the hand, but upon removal of hand the head soon returns to its former position; pupil contracted. The only muscles now starting are the right serratus magnus and the right half of diaphragm, though respiration does not seem to be interfered with to any extent. Cannot be induced to answer when spoken to; but he still evidently understands, his eye following me around the room.

Last night patient had a series of epileptiform convulsions in which he screamed and struggled violently with the right limbs, but did not bite his tongue. Takes food well, and never, since the commencement of the attack, has he made any attempt at vomiting.

March 19th.—Patient sank into a quiet sleep last evening from which he could not be roused, and died in coma at one o'clock this A. M.

At the post-mortem, twelve hours after death, the only parts that could be examined were the brain, orbital tumor and cervical gland. On taking off calvarium a remarkable absence of Pacchionian bodies, and the great ease with which skull-cap came off were only things noticed. The dura-mater was not much congested, and upon slitting it up and extracting the brain not more than an ounce or two of blood and serum together ran out. It was found that the dura-mater was adherent to pia-mater on either side of the falx over the upper ends of the ascending frontal and ascending parietal and over anterior fourth of post-parietal convolutions, especially upon the left side.

After the brain had been removed from the skull, the dura-mater over the left orbital plate, was followed through the optic foramen

and became lost in the fibrous covering of the tumor, which consisted of the periosteum of the orbital fossæ. The tumor could be peeled out cleanly from this fossa except opposite the frontal sinus, and towards the inner side, where it was found to have perforated the os-planum of ethmoid. In both these situations a portion of the growth was left. In order to extract this tumor the orbital plate of the frontal was broken through with a chisel from above. The orbital plate was not found to be at all involved in the disease. The microscopic appearances of this growth will be found below.

The gland from the right side of the neck was attached deeply but had not its fibrous sheath perforated. It was typically melanotic. There were several more small glands infiltrated, not discovered during life.

The pia-mater was not adherent except at certain spots, as stated below. Weight of brain 50 ounces—Substance dense—*cerebral convolutions:* Both on external surface, beneath and not involving pia-mater generally, sometimes involving this membrane and coming off with it, and in the white substance near the gray matter, masses of melanotic matter were found disseminated throughout. These masses varied in size from microscopic spots to collections a quarter of an ich in every diameter, and in one or two places even reaching nearly half an inch. Upon the surface the greatest number of these spots were located upon the right superior and middle frontal, and ascending frontal and ascending parietal (Ecker,) convolutions. They were also found upon the surface of the calloso-marginal gyrus and gyrus fornicatus of the right hemisphere, and upon the left hemisphere, superior surface in front of the sulcus centralis but not so thickly studded as upon right. All these masses were large, averaging the size of a pea. Everywhere that a cut was made, in the anterior, middle or posterior lobes, these black masses were found; the larger ones being on the surface. It is impossible to estimate the amount of distruction to the cortical substance by their presence but it must have been very great. The foreign matter seemed to have formed little spaces in the brain substance and when they were enucleated, which was easily done, they left small clean pits; the fibres of the brain were seemingly only pushed aside for their reception.

In several places the deposits had blood-clots around them, but generally there were none, and in each hemisphere was a large extravasation. That on the right involved, superficially, only the ascending parietal convolution, pushing aside the fibres of the convolution, appearing under the pia mater, and, dipping down into the white substance below, formed a pear-shaped mass of clot about one inch by two-thirds of an inch in size. There was also about one drachm of fluid blood in the cavity.

The hemorrhage in the left hemisphere involved the ascending frontal, and, partly the ascending parietal convolutions, superficially, dipped down into the white substance about two-thirds of an inch, and then, tearing up the perpendicular fibres coming from the convolutions, extended forward longitudinally with the long axis of the brain about one and a third inches. This cavity also contained a small quantity of fluid blood.

Condition of inner portions of cerebrum:—There was one minute spot in corpus callosum, none in fornix or velum interpositum. Five moderate sized masses in right choroid plexus; four in left. Two very small in right hippocampus major: a number in left hippocampus.

Corpora Striata: *Intra-ventricular portion* on left side showed four points of the average size of No. 7 shot, pushing up the lining membrane of the ventricle, and, in the case of the largest mass, bursting through it. Deeper down there were very few spots. On right side one very small mass could be seen beneath the lining membrane, but there were several masses deeper. The extraventricular portion of the ganglion contained only a few small points on either side. Optic thalamus of either side rather thickly studded with small masses.

None were found in crura cerebri, corpora quadrigemina, valve of Vieussens or medulla, and but very few, and those minute, spots in the pons varolii.

Both hemispheres of the cerebellum were riddled with black masses; more especially was this the case in the posterior portions; around many of these spots, which varied in size—the largest being one-half by two thirds of an inch, were blood clots. These bloodclots evidently varied as much in age as in size, but the

size of the clot did not correspond in every case with that of the mass. In one spot there was an aggregation of these masses, and there the surrounding brain substance was of a diffused brown color. Everywere in the substance of the brain the melanosis took place around the vessels, which would account for the majority and larger masses being upon the surface.

There were loose clots in the arteries at the base of the brain but no black deposits were found in their coats, nor was their calibre anywhere occluded. The specimens were preserved.

REMARKS:

This case is an extremely interesting one for several reasons:

First.—Because it follows the history of a case of sarcoma of the orbit, from the earliest manifestations of the disease to death four years afterwards.

Secondly.—The mode of cerebral involvement was plain; through the blood-vessels. This is the established belief, but, if sarcoma is only absorbed through these vessels, why did we have the cervical glands involved, and those upon the right side? Again, why did we have no symptoms pointing to chest trouble, the place where they should have shown themselves first? Moreover, there were no deposits in any of the sinuses, which were examined. (I regret exceedingly, that the chest was not examined before or after death, but the interest of the case lies in the cerebral lesions.)

Thirdly.—With such wide-spread and great involvement of the cortex the intellectual condition was remarkable. It is only another evidence of the capacity of accommodation possessed by the brain.

Fourthly.—Why did paralysis of the right limbs come on February 25th and irritative palsy on March 11th? I believe these two conditions can, in part, be explained by the difference in character of the two extravasations in the cerebral hemispheres spoken of above, and if they can thus be explained, is strong corroborative evidence of Ferrier's views. The symptoms on the left side of the body, the muscular startings, closely simulated those produced by him when irritation was applied to the same convolution. On the left side of the brain the clot, by extending horizontal-

ly, tore up the fibres coming from the motor centres, while on the right these fibres were only pushed aside. Still, the generally diseased condition of the brain would somewhat destroy the value of the observation. I would, however, state that in a case some time since in my care, where the ascending frontal and parietal convolutions of the left side, were the only portions of the brain occupied by a soft malignant tumor, the symptoms were similar.

Fifthly.—The appearance of the symptoms could be referred to the extravasations, I believe, and their disappearance to the fact that the already abnormal brain, though shocked for the time, was accommodating itself to the new condition. The density of the brain, and great variety in size of the melanotic masses, were strong evidence of the deposit having been going on for a long time.

Sixthly.—What symptoms detailed above would have led to a suspicion of the condition found in the cerebellumn? And why was there no reflex action on tickling sole of foot? To be sure, the spinal cord was not examined, but there was no suspicion of its involvement up to Febuary 25th.

Seventhly.—The diagnosis was made that the new growth had, in all probability, involved the orbital plate and dura mater, if not the brain substance, and the symptoms of right-sided paralysis seemed to give confirmation of this. When the other symptoms, or left muscular startings, came on they where referred to some accidental cause involving the convolutions—ascending frontal and parietal of right side most probably. On account of the first diagnosis, an operation, for which the man came into hospital and which he earnestly desired, was considered unjustifiable; this diagnosis, the sequal proved incorrect.

REPORT OF MICROSCOPIC APPEARANCES OF ORBITAL AND CEREBRAL TUMORS, BY DR. N. G. KEIRLE.

The tumor (orbital) is a melanotic round-celled sarcoma. The microscopic histology of the orbital tumor is the result of elementary involution of fibrous tissue which has undergone retrograde metamorphosis into spindle-cells; the nuclei and protoplasm of these cells, by repeated division and proliferation, give rise to numerous irregularly rounded cells, with large, prominent

nuclei. These cells, which are decidedly larger than white blood corpuscles, are, in some situations, disposed linearly in the site of the fibres from which they originated; in other places, by their increase in size and number, they so push aside and dispose of the remnants of the fibres as to form, for themselves, a network therefrom; again, elsewhere, so rapid and numerous has been the proliferation of these round cells that they have utterly destroyed the fibres from which they sprang, and occupy and form for themselves alveolar spaces in the surrounding connective-tissue stroma, and here culminate in alveolar-medullary-sarcoma—sarcoma-carcinomatodes.

This growth probably had its seat at first in the choroid—rich in vessels and in cells which derive their pigment therefrom; its original point of departure may have been the endothelia of the vessels. Tending to confirm this conjecture is the fact that in or about the middle of the alveolated cell-spaces, beforementioned, there exists sometimes a large vessel and, where this is the case, the accumulation of round cells is markedly greater than where the vessel is absent; but as the section was made transversely to the vessel its endothelia did not come into view and its condition as to proliferation or impigmentation in this situation remained undecided.

Sections of the brain were more fortunate and their microscopy decidedly more interesting in general and more satisfactory in particular, (both) as relative to the endothelia in its condition of proliferation and impigmentation, (and) as also to the point of departure or original imparture of the morbid impulse.

The general point of interest is, that microscopic observation prevents an error which would be most excusable if we were restricted to gross inspection. I mean the erroneous conclusion and inference that the cerebral phenomena are the results entirely of embolism—are chiefly embolic infarctions. A section, made through and around the small-bird-shot-sized black masses, longitudinally to the vessels which contain them, shows that these masses are composed of the endothelia of the adventitia luxuriantly proliferated and abundantly impigmented, yet the pigment is not all-pervading, for considerable masses of cells are destitute

of it. To account for which there are both certain fact and plausible theory; the first being that these cells are not abinitio pigmented but colorless; for often a long time elapses before they stain themselves. The other is the probable inference that the exuberant cell growth, which has converted the minute vessels, and their still more minute divisions, into solid cylindrical branchlets composed entirely of cells, shut off completely, at an early period of the circulation.

PRACTICAL REMARKS ON THE DIAGNOSIS OF THE EARLY STAGE OF BRIGHT'S DISEASE.

BY A. B. ARNOLD, M. D., PROFESSOR PRINCIPLES AND PRACTICE OF MEDICINE, WASHINGTON UNIVERSITY, BALTIMORE.

A satisfactory account of the symptomatology and course of chronic Bright's disease is one of the most difficult tasks of systematic writers. This is especially true of the early stage of this renal affection. The mere enumeration of symptoms will afford little assistance in identifying it under the variety of walks it may assume. Such a picture can only represent a bald and lifeless lay-figure, wanting in those features that would render it a true copy of the clinical reality, with which the experienced practitioner is familiar. It must have often occurred to many observers, who studied the peculiarities of this disease as it came under their notice, that the underlying renal lesion could hardly have been always of the same character; and it is therefore not surprising that a number of eminent pathologists call in question the correctness of the accepted opinion, that the different anatomical changes of the kidney, found on dissection, indicate only different stages of the same morbid condition. From the time that Grainger Stewart first recorded the results of his renewed investigations concerning this point of renal pathology, to the recent publications of Prof. C. Bartel's clinical lectures upon the same subject, the conviction has been gaining ground that the morbid appearances of the kidney, observed in many examples of albuminuria, are due to a peculiar pathological process. If the small contracted kidney in the greater proportion of instances, is not preceded by the stage of enlargement of that organ, then an explanation is afforded of some of the dissimilarities exhibited in the clinical history of what is called Bright's disease, and to which I shall presently refer. In using the uncompromising synonym, albuminuria, it is of course understood, that the mere presence of albumen in the urine is not considered to imply the existence of a primary renal disorder. Albuminous urine, is well

known to be frequently found in organic disease of the heart, in many acute febrile disorders, in cachectic conditions of the general system, &c., &c.

The following brief sketches of several groups of symptoms, in which the practitioner will at once recognize insidious or masked cases of albuminuria, serve to illustrate some of the difficulties involved in their diagnosis :

A robust, healthy-looking man complains of severe headache, resembling hemicrania, which comes on at irregular periods. Vision is slightly impaired. Occasionally the violent paroxysms of neuralgic-like pain about the head and face terminates in vomiting. Dyspeptic symptoms, without any assignable cause, are present during the intervals. In some of these cases the symptoms mentioned are of such a mild character, that the patient is apt to pay but little attention to them. At times a diarrhœa supervenes which does not yield to the ordinary remedies. Sooner or later, the patient becomes aware of his failing health, which he attributes to the gastric or intestinal disturbance. The medical attendant begins now to suspect that a more remote cause may be at the bottom of the evident anæmia, the pallor of the face, the slightly puffed appearance of the eyelids and the feeling of increasing debility. There is usually some œdema about the ankles, if looked for, but the examination of the urine clinches the diagnosis. Perhaps, long before this, an ophthalmoscopic exploration would have demonstrated the presence of renal retinitis.

Another set of symptoms, also apparently located about the head, may take the place of the neuralgia. There is frequent flushing of the face, ringing of the ears; the eyeballs feel hot and heavy, and there is a sensation as if the head was compressed in a vice. Sleep is disturbed, and during the waking hours the patient complains of languor and a general indisposition for physical and mental exertions. Instead of these signs of active cerebral congestion, an unaccountable somnolency may be the prominent symptom. Increased action of the heart, which sometimes amounts to annoying palpitation, is invariably present, and probably explains the occurrence of the head trouble. The subse-

quent appearance of anasarca seems to abate the disturbance of the brain.

The disordered movements of the heart may be the most obtrusive symptom to which the attention of the patient is directed. Physical examination will often detect hypertrophy of the left ventricle without the presence of valvular disease. The pulse is quite characteristic: it is hard and jerking, owing to increased arterial tension. This condition of the heart and pulse, if not associated with other signs and symptoms that point to the probability of renal trouble, will induce the careful physician to extend his examination beyond the determination of the cardiac disorder. Experience teaches that hypertrophy of the left ventricle is seldom absent in cases of contracted kidney; it is in that form of Bright's disease, where the dropsy is very moderate or altogether absent, and where the patient is apt to be suddenly seized with coma, or epileptiform convulsions.

The rapid development of œdema or congestion of the lung in this disease, especially towards its close, is well known. But I have observed the occurrence of this formidable pulmonary affection at a very early stage of albuminuria, when only the subsequent detection of slight anasarca gave a clue to the true nature of its pathological antecedents. On further inquiry, the physician, who may have been called to attend the patient for the first time, will hardly fail to elicit the information that a bronchial catarrh accompanied by considerable dyspnœa had existed for some time. Elderly people who are mostly subject to such intercurrent attacks of pulmonary congestions are also frequently troubled with erysipelas and phlegmonous affections of the skin.

A most interesting point in reference to scarlatinal dropsy relates to its prognosis. Although the majority of these instances of acute Bright's disease do well without any active treatment, there occur others which prove to be unmanageable. According to the observations of Abeilie, it appears that those cases in which albuminous urine is detected during the eruptive stage, will generally have a favorable termination, while in the the event that the albumen be discovered in the desquamative stage, the final issue is

very doubtful. With regard to the treatment in severe cases of scarlatinal dropsy, which are apt to end fatally by the abrupt occurrence of convulsions or coma, I am strongly of the opinion, that prompt abstraction of blood by venesection or cupping, followed by brisk purgation are the best means of guarding against the implication of the nervous system, and of cutting short the course of the disease. Prof. Jacobi of New York has recently urged the adoption of the same plan of treatment. Among the precursory symptoms which may be considered to indicate the effects of uræmic poisoning, the following appear to me of chief importance: Violent headache in older children, followed by incessant vomiting of bilious matter, carpology, fibrilation of the muscles of face and neck. Suppression of the urine is invariably fatal.

I would add, as a matter of personal experience, that the routine employment of the Tincture of Iron in acute or subacute forms of the disease, for the purpose of checking the draining of albumen, has the disadvantage of diminishing the elimination of the effete substances by the kidneys.

URETHRAL STRICTURE.

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During the past three years the attention of Genito-Urinary Surgeons has been especially invited to the study of urethral stricture, their pathology and treatment. The fresh interest in this subject is, in great part, due to the new departure of Prof. Otis, as to what constitutes a stricture. Heretofore, the French surgeons have taught that an urethra through which a twenty-one of their scale could be passed is free from stricture. According to the English school, if an eight or nine of their scale can be passed into the bladder, no stricture can be said to exist, whilst the American standard of 31½ millimetres was quite universally accepted as correct. In opposition to these current views, it is claimed, as the outcome of many experiments, that there is no such thing as a "standard urethra," which applies to every man any more than a standard hand or foot, but that as they vary in size in different individuals, according to the physique. So the urethra varies with the size of the flaccid penis. It is moreover claimed that this variation is definite and according to a rule; beginning with a penis three inches in circumference, its urethra would measure 30 millimetres, and for every ¼ inch increase in the circumference of the penis, there would be an urithral increase of two millimetres. These results have been verified by Otis in nearly all of 500 examinations. The establishment of this proportionate relationship, if sustained, would be a valuable addition to both Anatomy and Surgery, and for the purpose of testing its correctness many investigations have been made—notably by Drs. Hy. B. Sands, Weir, Mastin and myself in this country, Teevan, Watson, Berkley Hill, Cooper and Coulson in Great Britain—with a result that is anything but satisfactory.

The second important claim put forth by Dr. Otis—that of the uniform calibre of the typical urethra throughout—has been as

vehemently denied as asserted. The third proposition and perhaps most important in a practical point of view, is that which relates to results of treatment. It is insisted upon, and if true the argument is a sound one, that operations performed in accordance with the rules laid down, followed by the proper after-treatment, yield perfect results and complete cures, cures so complete that the previous seat of stricture cannot be detected by a properly sized olive sound, and so complete that the danger of re-contractions no longer applies,* enabling the patient to dispense with the dependence upon the introduction of the sound for the purpose of keeping his urethra open.

The fourth point is, that by far the most strictures, in fact nearly all, are found in the spongy urethra. This contrasts with Sir Hy. Thompson's position, who locates sixty-one per cent. in the membranous, or bulbo-membranous part, and is doubtless to be explained by the fact that the anatomical basis of the former's collection of cases and that for the latter, are distinct and dissimilar. The coarser procedure of the one ignored, as having no existence what the more refined method of the other esteems important and demands treatment. Hence it is that we hear so much of late about strictures of large calibre; not only because they are morbid conditions of themselves, but chiefly because they are apt, if let alone, to go from bad to worse, and sooner or later impair seriously the efficiency of the organ. It will be observed that this advance seems to take no account of the by no means dis-established assumption, that slight constrictions not only may be present, but may become harmless in the course of time, undergo absorption, or by a process of infection, (strictly rendered) take on the structure and function of the tissues in which they are seated.

These are the salient points of this new method, and the importance of keeping our premises constantly in view must explain this reference to what, after a fashion, is already before the profession. And whilst we must admit that the author has conducted his investigations with commendable fairness and zeal, we must

* See reference to report of Prof. Alfred Post, Drs. Miner, Woodruff, upon an examination of patient operated upon for five (5) strictures "with complete absence of a trace of stricture."

also regret that his challenge of criticism has not been accepted. We have had any amount of *a priori* reasoning presented against his formidable array* or on the other hand such complacent acceptance of the claims, both alike damaging to the cause of truth, that we would pronounce not so much "not proven" but "not tried". The trial has made little progress, the case is still open with all the presumptions necessarily favorable to Dr. Otis' side. Let us briefly consider some of the results of the trial as far as it has progressed.

"As to the question of the normal urethral calibre, Sir Henry Thompson, who has all along been the great champion for small sounds, has recently admitted that† "he had long seen the practical necessity of a higher estimate of the normal urethral calibre than that generally assumed." With this sentiment Mr. Berkley Hill, of the University College Hospital, London, agrees, and for the sake of illustration I quote the following of his:

"I did Syme's perineal section in a case of traumatic stricture lying in my wards, and who had been several weeks in Guy's and St. Bartholomew's Hospitals, and under private treatment before he came to me, without any instrument's having reached his bladder. I measured the circumference of his flaccid penis, and found it 3¼ inches. I turned to my audience and said: 'now according to Dr. Otis's observations, this urethra should easily admit 32 F.' I took up 32 F. sound, (at the size a general murmer ran round); I placed it in the meatus and it slid down to the bulb quite by its own weight. Then it was stopped of course by the stricture. I then proceeded to divide the stricture upon a Syme's grooved and shouldered staff in the perineum; the thick part of the staff was No. 26. I held it up to the audience along with the usual one of No. 16, to show the difference. After division I took the 32 F. sound again and slipped it readily into the bladder." In connection with another case he states, "I divided a contracted meatus this afternoon in a private patient, (his own doctor being in attendance); after which No. 39 F. passed readily down into

*See Sands "on the causes of gleet and calibre of the male urethra". New York Medical Journal, March 1876. R. F. Weir, New York Medical Journal, April 1876. Boston Medical Journal, November 1876.

†See report on advances in Surgery, Virginia Medical Monthly, January 1876.

the bladder, as I had announced that it would when I measured the canal with the urethra-metre. I then made the practitioner pass the 39 himself, in order that he might be sure that there was no hocus pocus in the matter." Testimony of this character must carry weight, especially when it is considered that the cases cited evidently constitute parts of a series. It is scarcely necessary to argue farther, this need "for a higher estimate of the normal urithral calibre." So far as my own examination of nearly one hundred cases extends, whilst not prepared to affirm that the *exact proportionate* relationship between penis and urethra exists, I am convinced that the capacity of the urethra is much greater than has been supposed and that the size of the urethra bears some ratio to the size of the penis. It is important to state here that all of my measurements were made with the urethra-metre, a most invaluable instrument. The amount of benefit, however, derived from its use depends upon the skill and delicacy acquired by long education in its manipulation. And under no circumstances must the "limit of easy distension" apply to the patient, except to a minor degree. That "feeling of fulness" referred to the patient, "sense of distension" must be regarded as too varying to make it the "sine qua non" of a grave surgical operation. As stated above, my examinations do not justify me in conceding the relative size of penis and urethra, so far as the measurements of the latter were made with the urethra-meter. This may spring from a want of proper tact in handling it.

In certain examinations it was quite evident that the same penis in a state of flaccidity may vary in its dimensions, when exposed under different temperatures, also that there were variations in different parts of the same organ—the point near the peno-scrotal angle measuring less than immediately behind or at the corona glandis; in fact does not the nature of the tissue of which the penis is made up suggest such conclusions? Under such circumstances as these what part must be selected as standard? With the statements of Prof. Sands, and Dr. R. F. Wier, that contractions occur in different parts of the normal uretha and are not prima facie evidence of disease, as indicated by a seris of eight carefully prepared wax casts, my investigations do not agree. In all instances

where obstructions to the easy movement of the urethrameter were met with, there was abundant reason for suspecting disease. The converse is equally true that where the urethra was found to be normal, the withdrawel of the instrument was accomplished without resistance. These and the post-mortem experiments serve to convince me that constrictions do not belong to normal urethræ, and where they do exist they must constitute the rare exceptions. It is a curious fact, which seems to have gone unnoticed, that in both of the collections of casts referred to the principal narrowings were in the anterior half of the urethra, a possible effect of the injection not continuing in the same state of liquefaction throughout, or again, if this supposition be not correct, might not these few cases when placed beside Prof. Otis' 500 cases, be classed with urethræ in a state of disease. This is especially probable when we recall the fourth proposition as to the most frequent site of stricture, a position which I fully indorse. Out of nearly 100 strictures divided by myself, including many that are usually designated as impermeable, at least 75 *per cent.* were found within the anterior 4½ Inches. I am therefore led to infer that those deeper constrictions are nearly always the consequence of extension of disease from in front. With reference to the controversy as to the existence of the boat-shaped dilatatation—the fossa navicularis—I have been forced by my post mortem, rather than by the urethra-metric inquiries, to consider it to be the rule for this, or at least some form of dilatation to be found. In my examinations, not exceeding a dozen, to be sure, made according to the directions of Malgaigne and Thompson, it was always present. I feel however almost convinced that it is acquired and not congenital, and dependent upon the constant and increased tension to which this part is subjected in the resistance to the exit of urine offered by a contracted meatus. For the purpose of determining this point, I have examined a number of fœtal and infants' urethræ, some of them in the presence of my colleague Prof. Bevan, and up to this time I have met not *a single one* in which this dilatation occurred. In all of these examinations the meatus was invariably found to be narrower than the rest of the canal. As an evidence of how utterly un-

reliable our hitherto arbitrary mode of excluding strictures really is, I would cite from among a number, the case of Wm. ——, in attendance upon my clinic, as an out-patient, at the College of Physicians and Surgeons. The size of his penis was 4¾ inches, and upon introducing the urethra-meter, and expanding it to what I believed the proper size, the indicator marked 47 millimetres. Without any more than the usual discomfort, and but very inconsiderable pain, it was withdrawn easily along the entire urethra, it only becoming necessary to diminish the bulb at the meatus, and at that point to 35 millimetres. Now in this case how very unreasonable it would have been to have allowed the introduction of a No. 8 or 9 of the English, 21 of the French and 31½ of the American scale to effectually dispose of the question as to whether there was stricture in that man's penis or not, when not one half of its normal calibre had been ascertained. And even taking his meatus as the guide, its indication would have fallen short to the extent of 12 millimetres. I am therefore compelled to agree with Prof. Sands, that "in practice we find in the size of the meatus a rough test for the calibre of the urethra," a test indeed so very rough and unreliable as to preclude our making any use of it in an operation which has for its object a complete division of the stricture.

From what has been said, I am forced with the qualifications stated, to agree with the principles contained in this postulate, and to decide that the old methods of examinations abound in faults. Under its teachings very decided disease must have been overlooked, and an easy explanation of the intractability of that bug bear-gleet, now recognized as the offspring of stricture, obtained. In passing I may state here that this dependence of gleet upon stricture has been greatly misunderstood, because when the stricture has been effectually divided, the urethral discharge did not cease. Many have considered this to disprove the connection, but this is obviously unjust, for the reason that the stricture was not the gleet per se, but the cause of it, and in a way easily to be explained. The obstruction favors the accumulation withni the urethra of residual urine bound to undergo decomposition. This urine, acting as an irritant, constantly applied, especially to

the sinuses of Morgagni, induces a chronic catarrh, which requires after the division of the stricture, treatment of the most persistant, discouraging character. As it is true that all acute diseases tend towards recovery, it is equally true that all chronic diseases tend, with as much emphasis, in an opposite direction. This, we all must admit, holds true of gleet. I am not prepared here to explain those cases of gleet, wherein the discharge had contined over such a period that analogy would warrant an assumption of stricture, and which are said to have disappeared entirely upon expectant treatment. I can only say that I have met with no such cases during these investigations, and feel inclined to question the completeness of the alleged recoveries. On the other hand, I have met with a number whilst presenting a somewhat similar history, they have, in addition, complained of a peculiar susceptibility to contract "fresh cases" of what they called gonorrhœa or simple urethritis, contracted whether after legitimate or illegitimate sexual indulgence; after "taking cold," or after slight excesses in eating or drinking. By way of illustration I extract from my "Case Record" a brief synopsis of two cases:

Case 1. Mr. ——, Jr., contracted four years ago a case of gonorrhœa, which after the usual treatment and a long time "got well". Has noticed since that time that scalding with urination and a discharge would follow sexual intercourse. This discharge, which, the patient states, is like that in his previous attacks, when seen by me, was not the frank, purulent discharge of gonorrhœa, but was decidedly more serous, though the usual symptoms of irritation were present. I observed that during urination the stream was too small, somewhat twisted and followed by dribbling. An attempt to pass 32 F. was made but failed, this being the size indicated. Before the canal could be traversed it became necessary to use the smallest olive in my possession, which is marked 13, F; the contractions being so considerable as to prevent the use of the urethra-metre until after a Thompson's divulsor had been introduced and dilated. Three distinct strictures were made out —one 3 inches, the second 2½ inches, and the third 1½ inch from the meatus, all of which were completely divided. Now this man

considerd his penis well, except as to these recuring attacks of gonorrhœa.

Case 2 presents almost identically the same history, except as to the number of strictures, there being but one, and as to the suspected cause of his urethral attacks—"cold". The stricture, located in this instance 2⅛ inches from the meatus, was alike perceptible to myself and to his physician, Dr. Saltzer of Baltimore. In both cases, the usual after-treatment of the tri-weekly introduction of the proper sized sound was followed out strictly and with good results.

Another point, in this connection, is the alleged insignificance or harmlessness of strictures of large calibre. Before accepting this there is need for more extended observation. I fully endorse the claim of the pathologist that this simple cicatricial tissue is liable to increased hyperplasia and liable to become not only a more and more serious condition in itself, but also liable, even in its early stages, to produce consequences that may prove dangerous and even disastrous. If space permitted I should like to give the details of two cases in point; the first that of a man dying in the Hospital of the College of Physicions and Surgeons from toxremia consequent upon extravasation of urine through a hole in the urethra 1¼ inch long, beginning just behind a stricture through which a No. 12 Van Buren's conical sound could easily be passed. The second case occurred in the practice of Mr. Walter Coulson, of the Lock Hospital, London, and is reported in the *Lancet* of August 28, 1875, page 332–333, in which perineal fistules, refused to heal after the usual section, until some strictures of large calibre, anterior to the fistulous openings, were freely divided. After this the patient entirely recovered. The anterior strictures were large enough to admit a No. 10 E. and still they offerred sufficient resistance to the flow of urine to keep the false passages from healing. I do not mean in either of these cases to dissent from the now generally accepted opinion, that perfectly normal urine is innocuous when even incjcted under the tissues, but more than probable in both of these the urine was not normal.

These are some of the notes which I have wished to make about that which I hope and believe will become a valuable addi-

tion to our fund of surgical knowledge. At some future time I propose to extend these comments, especially with reference to the results of the operation, not sufficient time having as yet elapsed to make me willing to venture an opinion. I feel justified in stating, even now, that I have made re-examinations where the strictures have been completely divided, nine months after the operations, without finding re-contractions.

EDITORIAL.

ANNOUNCEMENT.

In establishing a new Medical Journal and bespeaking for it a favorable reception at the hands of our professional brethren, we feel that some explanation may not unnaturally be expected of the motives which have led us to engage in this work, and of the mode in which we propose to conduct it.

It may be thought that the need for periodic medical literature is more than supplied, and that there are already too many Journals before the profession, claiming its support both in the way of subscription and of literary contribution. Anticipating and forestalling this criticism we admit freely at the outset that of portions of the field of medical journalism it is no doubt true. One able Quarterly, showing all the energy of youth, and get dignified by age and by connection with the historic past of American medicine, is a fit representative of the profession before the world, and supplies a medium for presenting the more profound results of study, which from their graver character must be comparatively infrequent, and can thus wait for the recurrence of quarterly periods. Several well managed and valuable Monthlies have passed that period of probation to the uncertainties of which all new ventures are liable, and have taken rank as accredited organs of professional opinion. And, last in the list, the success which has attended the medical Weeklies of England, has led to the establishment of journals of the same kind in this country, which commend themselves by the frequency of their visits as well as by their merits.

And yet with all this array there is room, we believe, nay more, there is need, for further enterprise in this department of literature. It must be admitted that a change has taken place in the way in which studies are pursued in almost every branch of knowledge. The present age in its literary, scientific and political aspects, is emphati-

cally an age of journals and magazines, which are the signs as well as the results of the rapid development and extension of thought.

The laborious student of former days followed up the subject of his investigations in all its connections with the past from its origin to its full development. He could read for himself all that had been written upon it by others. Especially was this true in matters of physical science, in which every one could verify observations without depending upon the authority of others. For a long time little had been accomplished, and advances were made but slowly. Now, however, another order of things prevails. The accumulations in almost all the departments of knowledge are so vast that no single mind and no single life can accomplish the mastery of the whole of any one. Much of what the student requires he must take upon authority, so that, furnished with the attainments of the past, he may be prepared to receive and appropriate the constant increments of the present. Thus authority acquires importance; and as rightly understood authority is justly entitled to be regarded as a guide between which and truth no real opposition exists. Communications must therefore be kept constantly open with those who are entitled to speak with authority; and authorities, however elevated their position, must always be ready to receive help from the humblest co-workers with themselves. To these ends continual interchange of thought is needed both in regard to what has been done, and to what is in process of doing. And this interchange can be effected only by such a medium as periodic journals afford.

In the affairs of nations the knowledge of important events was formerly gotten, so far as the general public were concerned, only after they became accomplished facts, the formed material of history. But now the very process of formation and of organization is open to inspection, and we see history, so to speak, in its nascent state. The communications between governments are given to the world; the newspapers tell us of a conference yesterday, a protocol to-day, it may be war to-morrow; and before our eyes the tissue of history is woven.

So in physical science the advances of the present era are largely due to the constant exchange of thought among those who are working to one end; each observation of value being transmitted to every observer in the same field. And this is accomplished in great part through the medium of scientific periodicals. For not only are the

original deposits of discovery made in journals, so that the earliest tracings of important truths, the "coming events" which "cast their shadows before," are often there to be found; but they serve the further purpose of handing on from mind to mind the truth once gained, and thus confirming what has been won, or stimulating further inquiry. With such a host of workers as now occupies the field of medical discovery ample space is needed for the records of their work; and for this reason we maintain that there is still room for more periodic literature to preserve and to disseminate the products of an age of restless, untiring activity.

A word or two in regard to the special occasion which we conceive to exist for a medical journal in this community.

Baltimore has been for many years a centre of medicine, the seat of medical schools, one of them among the oldest in the country; and of a medical society whose charter originated in the last century, and which is to-day in full and vigorous life. It will be ere long the home of still another school, whose munificent endowments will further stimulate labour and research in the laboratory and in the hospital. It is therefore high time, we think, that a place of such varied and important medical interests should have its own organ of medical thought and medical work. We propose to draw largely for our pages on the rich stores of clinical material which this city affords; and we are happy in having secured the assistance in our work of men who are occupied daily in the study, in the lecture-room and at the bedside.

For the rest, and apart from strictly scientific work, we shall endeavor to promote that broader culture to which medicine has in all ages been conducive, and thus to vindicate the ancient fame of our profession as indeed a learned one. We shall seek by every means in our power to maintain an ethical standard by conformity to which our common vocation as physicians shall be upheld above the rank of mercenary trades, and made the ministry for good that it is capable of being, not only to those who are the subjects of its beneficent labors, but to those also who pursue it as a calling.

We pledge ourselves and our fellow-workers to strive together for the common good of the profession, and with this aim,

> "Now leaving to the skill
> Of others their old craft sea-worthy still,
> We charter this; where mindful of the past,
> As true co-mates we gather round the mast."

And so, having launched our bark, in the hope of favoring gales, we ask the good wishes and the kindly aid of all our friends.

H. E. T. MANNING, M. D.
T. A. ASHBY, M. D.

Baltimore, May 1st, 1877.

TO THE PROFESSION.

A very large edition of the first number of the *Maryland Medical Journal* has been issued with a view of placing it prominently before the profession. Copies are sent to many physicians, who are not subscribers, in the hope that they will subscribe and contribute thereto, and induce their friends to do likewise. We invite a careful examination and respectfully solicit the approval and encouragement of the entire profession.

The size and character of the *Journal* will be increased and improved from time to time as circumstances may seem to justify, but the subscription price will always remain $3 per annum, *invariably* in advance.

OUR CONTRIBUTORS.

We are pleased at being able to announce that we have secured the assistance of prominent men in the profession throughout the country, (some of whom will contribute to each number), and we are safe in promising members of the profession a journal entirely worthy of their support.

Our corps of contributors includes prominent teachers and leaders in the profession in the states of New York, Pennsylvania, Missouri. Maryland, Tennessee, Kentucky, Virginia, West Virginia, North and South Carolina, Georgia and Alabama, whose names, alone, will ensure for their articles a warm reception and eager, attentive perusal.

OUR RESOURCES.

Baltimore, with its three prosperous medical colleges, (each with a large hospital), four or five flourishing medical societies, and numerous private and public hospitals, affords a fine field from which to draw material for a medical journal, and our readers shall have the benefit of these sources of information as far as we may be permitted

to use them. These, in addition to promised reports from hospitals in other states, will contribute largely to the interest and value of the *Maryland Medical Journal.*

SELECTIONS.

With this, the first number of the *Maryland Medical Journal*, the character and variety of the selections is necessarily limited, by reason of the fact that our exchange list is, as yet, incomplete.

It is our purpose to make this an important feature of our publication, and in future the very cream of home and foreign journals will be given in a form at once attractive and valuable.

OUR ADVERTISERS.

A limited number of advertisements have been received, their character and responsibility being the main elements considered, and we have no hesitation in commending them to the kindly consideration of our friends and patrons.

NORTH CAROLINA MEDICAL SOCIETY.

The medical society of North Carolina, will meet in Salem, in that state, on Tuesday, the 29th day of this month. The attendance is expected to be very large, as, in conformity with a recent act of the Legislature, the society will organize itself into a State Board of Health, and at once enter upon the duties imposed by said act.

ROCKY MOUNTAIN MEDICAL ASSOCIATION.

This association will meet in Chicago, on Wednesday, June 6th, 1877. Dr. Toner, the President, will deliver the annual address.

JNO. MORRIS, M. D., Secretary.

INTERESTING reports of the proceedings of the Medical and Chirurgical Faculty of Maryland, and the Baltimore Clinical Society, at their recent meetings, together with valuable selections, have been laid over until our June number, in order to make room for the able papers presented in this.

SELECTIONS.

SOLUTION OF INDIA RUBBER IN LOCAL TREATMENT OF PSORIASIS.

Mr. Wyndam Cottle has found this material useful in chronic cases of psoriasis, where there is an excessive formation of dry scales, especially in the neighborhood of the joints, where the scales form crusts, are hard, and render the movement of the part painful. The crusts and scales being removed, and the absence of grease insured by wiping the parts with ether, and the skin dried, a solution of the India rubber is applied with a brush, and the application renewed as often as is needful to maintain a continuous covering over the affected skin. He recommends a solution composed of India rubber half an ounce and chloroform eleven and a half ounces.—*Druggists' Circular.*

CHRYSOPHANIC ACID.

This new remedy, of great efficacy in ring-worm, will soon be familiar to our pharmacists. Mr. A. W. Postans, of London, who first prepared it, states that the easiest, simplest, and by far the best method of making it into an ointment is to dissolve the acid in hot fat. Two drachms will dissolve in one ounce of lard, but this is very concentrated. The hot ointment should then be transferred to a mortar, and rubbed down till cold.

If to each ounce of ointment so prepared two drops of otto of roses be added, a most beautiful preparation results, possessing in an eminent degree the active properties of the acid with the delicate and attractive odor of the rose.—*Ex.*

CURE OF PILES BY PUNCTURE WITH CAUTERY.

Dr. H. A. Rieves, in the *Lancet* of February 17th, describes a method by which, in eighteen cases he made a radical cure of piles, by puncture with the actual cautery.

Two or three punctures are made with the pointed cautery, and the bowels are kept quiet with morphine for a time. On the third or fourth day an enema is given, and at the end of the week the patient is discharged.

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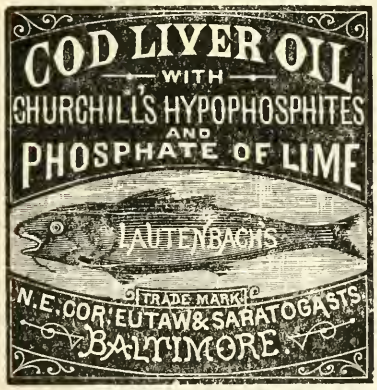

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SESSIONS OF 1877—1878.

THE COLLEGIATE YEAR in this Institution embraces a preliminary Autumal Term, Regular Winter Session, and a Spring Session.

THE PRELIMINARY AUTUMNAL TERM for 1877-1878 will open on Wednesday, September 19, 1877, and continue until the opening of the Regular Session. During this term, instruction, consisting of didactic lectures on special subjects and daily clinical lectures, will be given, as heretofore, by the entire Faculty. Students expecting to attend the Regular Session are strongly recommended to attend the Preliminary Term, but attendance during the latter is not required. *During the Preliminary Term, clinical and didactic lectures will be given in precisely the same number and order as in the Regular Session.*

THE REGULAR SESSION will begin on Wednesday, October 3, 1877, and end about the 1st of March, 1878.

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R. OGDEN DOREMUS, M. D., LL. D.,
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A. A. SMITH, M. D.,
Lecturer Adjunct upon Clinical Medicine.

A distinctive feature of the method of instruction in this College is the union of clinical and didactic teaching. All the lectures are given within the Hospital grounds. During the Regular Winter Session, in addition to four didactic lectures on every week-day, except Saturday, two or three hours are daily allotted to clinical instruction.

The Spring Session consists chiefly of recitations from text-books. This term continues from the first of March to the first of June. During this Session, daily recitations in all the departments are held by a corps of examiners appointed by the regular Faculty. Regular clinics are also given in the Hospital and in the College building.

FEES FOR THE REGULAR SESSION.

Fees for Tickets to all the Lectures during the Preliminary and Regular Term, including Clinical Lectures	$140 00
Matriculation Fee	5 00
Demonstrator's Ticket (including material for dissection)	10 00
Graduation Fee	30 00

FEES FOR THE SPRING SESSION.

Matriculation (Ticket good for the following Winter)	$ 5 00
Recitations, Clinics, and Lectures	25 00
Dissection (Ticket good for the following Winter)	10 00

Students who have attended two full Winter courses of lectures may be examined at the end of their second course upon Materia Medica, Physiology, Anatomy, and Chemistry, and if successful, they will be examined at the end of their third course upon Practice of Medicine, Surgery, and Obstetrics only.

For the Annual Circular and Catalogue, giving regulations for graduation and other information, address Prof. AUSTIN FLINT, Jr., Secretary, Bellevue Hospital Medical College.

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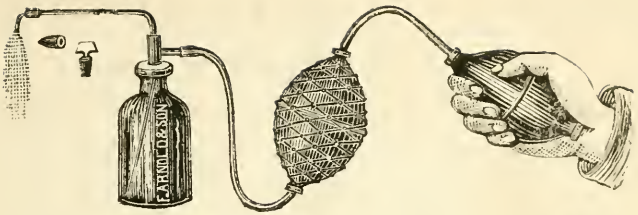

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